

<b>Case Number:</b>	CM13-0040590		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	09/22/2006
<b>Decision Date:</b>	04/22/2014	<b>UR Denial Date:</b>	09/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Family Practice, and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 60 year old female who sustained a work-related injury on 9/22/06 involving the neck, and back. Her diagnoses included lumbar myofascitis, multi-level disc disease, and lumbar facet syndrome. A recent exam on 9/3/13 indicated that she had cervical, thoracic and lumbar paraspinal tenderness, and difficulty with activities of daily living. Her assessment was determined to be unchanged from prior visits and she was prescribed topical analgesics, 6 sessions of electroacupuncture, radiant heat via an infrared lamp to increase circulation to the tissues, and cupping of the lumbar spine.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

#### **ELECTRO ACUPUNCTURE 1 X WEEK X 6 WEEKS TO LUMBAR SPINE AND CERVICAL SPINE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** According to the guidelines, acupuncture may be used as an option when pain medication is reduced or not tolerated. Acupuncture with electrical stimulation is the use of electrical current on the needles in the acupuncture site. It is used to increase the effectiveness of

the needles. The time to produce functional improvement through acupuncture with electrical stimulation is 3-6 treatments over 1-2 months, with a frequency of 1-3 times a week. Treatment may be extended with documentation of functional improvement. In this case, there is no documentation of failure of pain medication to indicate the necessity of electroacupuncture. The documentation does not support medical necessity.

**CUPPING 1 X WEEK X 6 WEEKS TO LUMBAR SPINE AND CERVICAL SPINE:**

Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**Decision rationale:** Cupping is a form of Chinese alternative medicine that mobilizes blood flow to improve healing via a suction device. According to the Official Disability Guidelines, reviews show that data published prior to 2003 have concluded that there is limited evidence that such methods is more effective than no treatment for chronic pain, and inconclusive that they are more effective than placebo, sham therapy, or standard care. In this case, there is no evidence of the failure of standard treatment including therapy and analgesics. Furthermore, there is a lack of evidence supporting cupping in the literature. The request for cupping is not medically necessary.

**INFRARED LAMP 1 X WEEK X 6 WEEKS TO LUMBAR SPINE AND CERVICAL SPINE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Disability Guidelines, and the Medicare Guidelines.

**Decision rationale:** Infrared heat is used to stimulate blood flow and improve healing. The MTUS and ACOEM guidelines do not make recommendations for infrared heat and pain. However, the Official Disability Guidelines do comment on heat wraps as an option. According to the Medicare guidelines, the use of infrared and/or near-infrared light and/or heat, including monochromatic infrared energy (MIRE) is not covered for treatment, including for pain arising from diabetic and/or non-diabetic peripheral sensory neuropathy, and wounds and/or ulcers of the skin and/or subcutaneous tissues. Based on lack of documentation of failure from standard therapies and lack of support from the guidelines, the request for infrared heat therapy is not medically necessary.